



physical therapy

speech • hearing • occupational

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www.maxumtherapy.com

Patient Name: _____

Date: _____

Diagnosis / ICD-9 Code: _____

Precautions: _____

Recommended Frequency and Duration: _____ time(s) / week for _____ week(s) or _____ day(s)

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Does this patient require Psychological Services? | <input type="checkbox"/> | <input type="checkbox"/> | Does this patient require Social Services? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does this patient require other Services not listed below? | <input type="checkbox"/> | <input type="checkbox"/> | Would this patient benefit from pool therapy? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered yes to any of the above questions, please describe the need in as much detail as you can provide.

- PT Eval & Treat as necessary OT Eval & Treat as necessary ST Eval & Treat as necessary

PROGRAMS

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Cervical / TMJ | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip / SI |
| <input type="checkbox"/> Thoracic / Rib | <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Lumbar | <input type="checkbox"/> Wrist/Hand | <input type="checkbox"/> Ankle / Foot |
| <input type="checkbox"/> Voice Training | <input type="checkbox"/> Accent Modification | |
| <input type="checkbox"/> Other: _____ | | |

MODALITIES

- Ultrasound
- Phonophoresis
- Electrical Stimulation
- Biofeedback (EMG Pressure / Tactile)
- Iontophoresis
 - Dexamethasone
 - Lidocaine
 - Other _____
- Paraffin Bath
- Hot Packs / Cold Packs
- Mechanical Traction
 - Cervical
 - Lumbar
 - Other _____
- LASER / Infrared Treatment
- Biodex Balance Trainer
- Short Wave Diathermy
- Other: _____

PROCEDURES

- Therapeutic Exercise
- Neuromuscular Re-education
- Vestibular / Balance Exercises
- Gait Training
- Sports / Dance Specific Rehabilitation
- Pediatric Rehab
- Work Hardening / Ergonomic Education
- Manual Therapy / Joint Mobilization
- Soft Tissue Mobilization / Myofascial Release
- Activities of Daily Living Training
- Assistive Device Fitting / Training
- Sensory Integration
- Other: _____

I certify that I have examined the patient and that the service required above are necessary and will be furnished while the patient is under my care. This patient and the plan of care will be reviewed every thirty (30) days or as the patient's condition or the payor so requires.

Referring Physician (Printed): _____ Signature: _____

Phone: _____ - _____ Fax: _____ - _____